**Phone: 1-877-537-0722**
**FAX TO: 1-877-537-0720**

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

**2011 - 2012 SYNAGIS**
**PRIOR AUTHORIZATION REQUEST FORM**
**Injections approved starting October 31 - March 31 for a maximum of 5 injections**

**BENEFICIARY INFORMATION**

Beneficiary's Name: _____Beneficiary's Medicaid #: _____

DOB: _____ City:_____
Month/ Day/ 4-Digit Year

**PRESCRIBER INFORMATION**

Prescribing Physician: _____ Medicaid ID: _____

City_____ State _____ Phone #: _____FAX:_____
_

***Mississippi Medicaid is a federally-subsidized health care program funded with public dollars. As such, I confirm that this medication will be administered to the patient for whom it is dispensed. If I or my staff are unable to administer this medication to the designated patient, I acknowledge that I am responsible for notifying the dispensing pharmacy immediately***

_____
Physician's signature and date

*I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.*

**PHARMACY INFORMATION –** Synagis® is available through a limited distribution network established by the manufacturer. The following list includes approved pharmacy providers from the 2011-2012 season. If the preferred provider for this request is not included in this list, please select other and provide pharmacy provider information (name, address, telephone number, Medicaid provider number, etc.).

☐ Accredo (Memphis, TN)

☐ North Mississippi Medical Center Pharmacy (Tupelo, MS)

☐ Transcript (Jackson, MS)

☐ UMC Medical Mall Pharmacy (Jackson, MS)

☐ VitalCare (Meridian, MS)

Other: _____

_____

_____

_____

_____

Beneficiary's Name: _____Beneficiary's Medicaid #: _____

**DRUG/CLINICAL INFORMATION**

NDC#:_____Gestational Age:____wks Birth Weight: _____lbs ____oz

Current Weight: _____lbs ____oz Date last weighed: _____

**First Season Requests:**

**Did the patient receive Synagis in the hospital? Yes No If Yes, list date(s) of administration**:_____

**Risk Factors:** Check all that apply to *first season* requests only.

| | |
|---|---|
| Chronic Lung Disease requiring medical treatment within the past six months (e.g. diuretics, systemic steroids, oxygen on continuous basis, bronchodilators or ventilator-dependent).<br><br>☐ Hemodynamically Significant Congenital Heart Disease | ***Supporting documentation must be available in the patient record.<br><br>☐ Severe neuromuscular disease<br>☐ Congenital abnormality of the airway<br>☐ Day Care<br>☐ School Age Siblings (<5 years old) living in the home |

**Second Season Requests:**

**Risk Factors:** Check all that apply to *second season* requests only.

☐ Severe CLD requiring continued medical therapy
☐ HSCHD (hemodynamically significant congenital heart disease)

Additional Rationale for Second Season:

| |
|---|
| |

***Supporting documentation must be available in the patient record.

RSV prophylaxis approval will terminate at the end of RSV season. Authorization will end at age two (2) on the last day of the child's birthday month.